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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 12 1945**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10026

State File No. \_\_\_\_\_

Registration District No. 173

Primary Registration District No. 4273

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Concordia Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Concordia Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LOUISE HINCK

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 30  
year 1945 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 1 - 1943  
to March 26 - 1945  
that I last saw her alive on March 29, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure ✓

4. Sex Female 5. Color or race whit

6. (a) Single, widowed, married, divorced 2

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 12 (Month) 23 (Day) 1866 (Year)

Duration \_\_\_\_\_

Due to arteriosclerosis 4 years

Due to \_\_\_\_\_

8. AGE: Years 78 Months 3 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Concordia Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy No

11. Industry or business \_\_\_\_\_

12. Name FIPANK Becker

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Becker Detmold

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Marie Fuchs

(b) Address Concordia Mo

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof 4 2 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Pauls Cemetery

18. (a) Signature of funeral director F. Shryman

(b) Address Concordia Mo

19. (a) April 2 - 45 (b) Mrs. Walter Walker  
(Date received local registrar) (Registrar's signature)

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

Signature F. Shryman (M. D. or other) \_\_\_\_\_

Address Concordia Mo Date signed 3-11-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

4  
1  
0

1231

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 4/11/45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed E. S. [Signature]

2959  
Licensed Embalmer No. \_\_\_\_\_

J. C. [Signature]  
1511  
P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 173

Primary Registration District No. 4273

Registrar's No. 5

1. PLACE OF DEATH

(a) County Lafayette

(b) City or town Concordia  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Louise Hinch

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Claus Hinch

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 23 1945  
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) April 2-45 (b) Mrs. Walter Wolfpen  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day \_\_\_\_\_ year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

Signature D. J. Shryman (M. D. or other) M.D.

Address Concordia Mo. Date signed 3-3-45

SUPPLEMENTARY

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

FILE

RECEIVED  
MAY 19 1962

10026

10026